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ABSTRACT

The first two of 16 booklets designed for use in an Open University course about handicapped children and their education in the United Kingdom, these texts present an overview of the course and a glossary of special education terms. The overview booklet outlines the course's major themes: understanding special education, meeting special needs in education, relating special education to the education system as a whole, and integrating children with special needs into ordinary schools. Additional overview material covers course components, a course outline, assessment procedures, suggestions for participating in the course, and major course aims. The glossary contains descriptions and definitions of physical impairments and related technical terms as well as of legislation and official reports concerning special education. Terms are arranged alphabetically while legislation/reports are presented chronologically from 1601 to 1981. An index is also provided that refers to an Act or report by its most common name.

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E241 G

The Open University
Supplementary Material
Educational Studies: A Second Level Course
Special Needs in Education

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GUIDE TO THE COURSE

Prepared by Sue Sheldon for the Course Team

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The purpose of this guide is to tell you about the course, its components and how to study it. General information about studying an Open University course can be found in the current *Student Handbook* and its supplements.

1 What kind of course is it?

E241 is a second level half-credit course about handicapped children and their education. It places particular emphasis on providing information and understanding about special education, and about the design and planning of the provision of this education. It is less concerned with the teaching techniques to use with handicapped children, though parts of it are directly relevant to this.

The course is a general introduction to the field, and will interest not only teachers in special and normal education but anyone with a concern or involvement in this area. Unit 1/2 gives a detailed introduction to E241 but, to give you some idea now, these are the four themes around which we have worked.

Themes

Understanding special education

We describe what special education looks like from the outside, and how it feels to actually be a participant in it. We do this from many points of view—the teachers' and other professionals', the parents', and the children's.

Meeting special needs in education

Here we look at how far children's needs are met by existing provision, and how education might better meet the needs of handicapped children and their families.

Relating special education to the education system as a whole

People tend to think of special education as an isolated system unrelated to general educational concerns. The two areas are intimately connected. Most children with special needs are, in fact, in ordinary schools. The course examines the connections between ordinary and special education and the way change in each affects the other.

Integrating children with special needs into ordinary schools

Since 1944 the law in this country has adopted the principle of integrating handicapped children into ordinary schools, yet since that time practice has been the opposite: there has been a steady growth of separate special schools. We look at why this is, and at the moral and practical arguments involved. We also examine how successful integration can take place.

2 Course components

Main texts

There are 14 books containing a total of 16 units; a brief outline of each is given in Section 3. Each text is linked to certain readings and case studies from the set reading, gives details of any further reading you might do, and tells you what broadcasts you should see or hear.

Set reading

There are two set books for the course:

SWANN, W. (ed.) (1981) *The Practice of Special Education*, Oxford, Basil Blackwell/The Open University Press (the Reader). This is a collection of research and review papers, either selected or commissioned for the course.

BOOTH, A. J. and STATHAM, J. (1982) *The Nature of Special Education*, London, Croom Helm/The Open University Press (the Case studies). This contains over 50 detailed case studies of many aspects of special education which illustrate and illuminate issues analysed in the units.

Broadcasts

There are eight television and eight radio programmes for the course, each associated with a particular unit. Details of broadcast dates and times can be found in the *Broadcast and Assignment Calendar*, which you will receive in the first mailing. At intervals you will also receive broadcast notes, which give you a synopsis of each programme and other related information. If you are unable to find time to listen to the radio programmes when they are transmitted, you can request audio-cassettes of them. Details of this scheme are given in the *Student Handbook*.

Tutorials

Seven hours of tutorial time are available to most students, spread evenly through the year. The detailed arrangements for your area will be made by your regional office.

Glossary

A separately bound item, the glossary comprises: (a) medical terminology, (b) statutes, government circulars and reports.

Tutor-marked assignments

These will be mailed to you in the normal way. Since you receive no grade on the first assignment, it will give you an unpressured opportunity to practice writing an essay as well as to become acquainted with your tutor. Section 4 gives details of the assessment pattern for the other assignments. Cut-off dates and instructions for submission are given on each assignment.

Specimen exam paper

In the final mailing of course materials you will receive a specimen exam paper, which shows the structure and type of questions you will meet in the unseen examination.

Charts

You will receive two charts: the first lists the major historical events in the development of professional involvement in special education, and the second describes the origins of special education (provisions, pioneers and legislation). You can add to these study aids as you want; they should be especially useful when you are working through Units 7, 8 and 9.

Literature guide

DALE, S. (1981) *The Handicapped Person in the Community: using the literature*, Milton Keynes, the Open University Press.

This has been produced both as a guide to making full use of library services, and as a reference work for your use during and beyond your direct involvement with the course. It gives hints on how best to use libraries, and also contains a list of the various reference books and organizations relevant to the course, together with guidance on how to conduct a systematic literature search. This guide was originally produced for P251 *The Handicapped Person in the Community*.

3 *Course outline*

In the first half of the course we describe and analyse the current system of special education in the UK, from the curricula that children and young people experience to the legal framework that governs children's, families', and educators' lives.

Unit 1/2 *Special biographies* introduces the course and the key issues. We describe children with a wide range of problems in the context of their families, neighbourhoods and schools. Using these examples, we show how handicap is the product of both individual characteristics and the social environment: children may be handicapped by physical impairments, by social backgrounds or by the education system. We then introduce the theme of integration, examining the moral and empirical issues that make up the debate, and describing the current position.

Unit 3 *Family views.* Here we try to help you to understand the problems that families with handicapped children face. We concentrate on the most severely handicapped children, and where possible use quotations of parents telling their own story. We then look at the services available to families to relieve or resolve their difficulties, and at the nature of the partnership between professionals and parents.

Unit 4 *Education for adult life?* jumps to the other end of children's school careers and discusses the extent to which children are prepared for economic, social and intellectual independence when they leave special education. The opportunities offered by schools, colleges of further education and universities are examined, and the way in which young handicapped people experience the problems and possibilities of independent living is discussed in detail.

Unit 5/6 *A special curriculum?* then returns to what actually happens in classrooms. Do children in special education actually receive a special curriculum? If so, how is it different from the normal curriculum and does it meet the children's needs? As in all components of the course we have to be selective, and so we concentrate on the curricula experienced by maladjusted children, children with learning difficulties, and physically and visually handicapped children. We ask where these curricula came from and what influences them, whether they are necessarily tied to special schools, and who is accountable for what goes on. We also go back to ordinary schools to ask how far their curricula create the need for special curricula, and whether a more flexible ordinary curriculum could reduce that need. We examine how children are transferred between schools, and between curricula.

Then, in Units 7 and 8 we step outside schools to look at professionals and the administrators. What do they do? What power do they have? Do they use their influence judiciously in the interests of handicapped children and their families?

Unit 7 *The professionals* looks at the armies of professionals in special education, at their jobs and their expertise. It explores what happens when practice exceeds its legitimate boundaries. The unit also looks at how professionals, including teachers, work together and, when they don't, why they don't.

Unit 8 *The powers that be* is about the law and how it is implemented. It describes the powers invested in local authorities and central government and how they are exercised, and examines who controls policy, how change takes place, and the all-important issues of finance and the way in which expenditure cuts affect special education.

The second half of the course looks further and deeper into the ideas and practices on which our special education system is based.

Unit 9 *Origins.* Special education has an involved and largely hidden past. Unit 9 traces how the present system developed and the factors that produced change. It examines the moral and social debates of the nineteenth and early twentieth century and the impact of mass education. Using this discussion as evidence, it asks how much progress there has really been.

Unit 10 *National perspectives* is about what happens overseas—in parts of the US, Scandinavia and Italy. The unit explores why things are done differently and how recent change in the direction of integration has come about. This discussion helps in an understanding of the political and legal determinants of special education.

Units 11, 12 and 13 are about our ideas of handicap and how they influence teaching practice and the design of provision.

Unit 11 *Biology and handicap* examines the relevance of biological knowledge in devising curricula, and the over-extension of biological and medical ideas to encompass many groups of children. It describes arguments concerning the social origins of some biological impairments via factors such as lead pollution, and looks at the general influence of medical ideas in special education.

Unit 12 *Psychology and special education*. Psychology is perhaps no less influential than medicine, and Unit 12 charts its importance—in the past through intelligence testing, and increasingly today through the use of behaviour modification. How have these ideas affected classroom practice, and have the consequences been beneficial? The unit also looks at some recent ideas in child development and at their possible benefits.

Unit 13 *Handicap is social* argues just that. All handicaps depend on cultural conditions which are independent of the difficulties of an individual. The meaning and value placed on a handicap may become part of the handicap itself. The unit discusses the beliefs and prejudices which give rise to stereotyped images of handicap, and the processes by which these are incorporated into the identities of handicapped people.

The last three units of the course look at the future of special education.

Unit 14 *Eradicating handicap* asks how we can prevent handicap and educational difficulties. It analyses medical, educational, social and political approaches to prevention.

Unit 15 *Research in special education* describes the resources of manpower, money and institutions that are devoted to research into special education. How much research is relevant to practice and how could it be made more relevant? What kinds of question can be answered by research, and what is its proper role in innovation?

Unit 16 *An alternative system: a special imagination*. Finally, Unit 16 describes a possible alternative system where handicapped children are provided for in the mainstream of education. It brings together ideas from the course to show the impact this would have on normal schools, and what services would be needed to support the children and teachers. It includes studies of institutions in the process of change and looks at participants' views on how they wish special education to develop.

4 Assessment

Continuous assessment

There are four tutor-marked assignments (TMAs), three of which count towards your course grade. There are no computer-marked assignments.

TMA 01 is a short *formative* assignment: it does not count towards your course grade.

TMAs 02–04 are normal length, *summative* assignments which contribute 45 per cent of your total course grade. E241 is one of the courses using the '100 per cent rule' for calculating your overall continuous assessment score. This rule makes it in your interest to complete all of TMAs 02–04. It is described more fully in the supplement to the *Student Handbook*.

End-of-course assessment

This consists of two components—an end-of-course essay, and an examination.

TMA 05 is the *end-of-course essay*; it is marked by your tutor, but the procedure is rather different from that of a normal TMA. We are treating this essay as part of your overall exam score worth 15 per cent of your total course grade. The unseen *examination* at the end of the course is worth 40 per cent of your total course grade.

Both TMA 05 and the examination are compulsory, and you must pass both of them in order to pass the course, except in exceptional circumstances.

Full instructions about the TMAs, end-of-course essay and examination will be sent to you later.

5 *Studying the course*

You may find E241 different from other courses you have studied, whether in the Open University or not. In devising the course, we have tried to get away from the idea that the only serious and respectable knowledge is to be found in books and research papers. As a result we have talked to many people in the field and visited many places to discover just what is happening in special education. Some of this work appears in the collection of case studies, other parts of it emerge as ideas and illustrations in the units. This is, after all, how books and research papers get written. In addition, *you* will have access to evidence and experience that no-one else knows about or has thought about, and you should use it in thinking about the course and in writing your assignments. Naturally you will need to do more than simply record your experience: you must consider the implications and meaning of what you have discovered, and relate it to ideas about the nature and functions of special education. In this way writing for the course can become a creative and original exercise.

On the other hand, this is not to dismiss reading as a source of information and ideas. At the front of most units you will find a short list of books that are fairly easy to get hold of, and that you can use as a start if you want to explore one area further.

What's happening in your area?

Although we expect you to have read all the units by the end of the year, we hope that you will do more than this. We hope you will be sufficiently interested to find out about what is going on in your area: talk to handicapped people, parents and professionals about what they do and think; ask questions about the kinds of special provision available and about the needs of your own area; contact local voluntary societies and pressure-groups and find out their views about local provision. Every unit in the course raises a mass of questions for you to ask about. The more you do this, the deeper will be your understanding of the issues. In this respect it is important to bear in mind that formal tutorial time is limited. You may find it very worth while to form a self-help group.

Planning your time

You will find that units differ in the amount of reading and study they involve. As a guide we expect an average unit to require 10–12 hours of study spread over two weeks, but we have not given any detailed guidance because we hope you will treat the course flexibly. Inevitably there will be parts of the course that interest you more than others: don't be afraid to devote more time to these and less to others. The design of the TMAs and examination allows for this. On the other hand, you will be expected to have done some work on, and be familiar with, all the units.

6 *Course aims*

Finally, the following aims give in detail the major themes of the course. They have been produced as a template against which the content of the course can be assessed. You may find it useful to come back to these from time to time to assess your own progress through the course.

Aims

To enable students to:

(a) Describe and evaluate

(i) the way of life that special education provides for all its participants;

(ii) the way special education prepares children for adult life;

(iii) the differing interests and perspectives of all the participants in special education;

(iv) the effects of handicap and special educational provision on the lives of children and their families;

(v) special educational practices and provision in relation to past developments and possible alternatives;

(vi) the reasons and justifications for present special educational practices and provisions.

(b) Assess the financial implications of different forms of special educational provision.

(c) Identify the educational needs of handicapped children and evaluate schemes for meeting them.

(d) Evaluate the usefulness and consequences of systems of categorization of 'special needs'.

(e) Distinguish moral from empirical questions in special education.

(f) Distinguish principles about integration from practical difficulties in its implementation.

(g) Understand handicap as a social and historical entity as well as a biological and psychological one, and evaluate the range of application of these approaches.

(h) Distinguish knowledge from beliefs about handicap.

(j) Describe the implications of knowledge about handicap for the appropriate education of children.

(k) Identify the mechanisms for change within special education.

(l) Relate practices and changes in special education to the education system as a whole.

(m) Devise and evaluate plans for the integration of children with special needs into normal schools.

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The Open University
Supplementary Material
Educational Studies: A Second Level Course
Special Needs in Education

GLOSSARY

Prepared by Patricia Potts, Sue Sheldon and Will Swann for the Course Team

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How to use this glossary

This glossary has two parts. The first contains descriptions and definitions of physical impairments, and their related technical terms. The second part describes legislation and official reports—mainly those that have appeared from 1850 up until the present—relevant to special education. We have prepared the glossary for use as you work through course material, to avoid the need for us to give repetitive explanations in the main texts.

Part 1 describes the principal physical impairments that can affect children and may be associated with educational handicaps. This part is arranged alphabetically. Some of the conditions and their implications are described in much more detail in other parts of the course. We have given here the minimum information necessary to understand the terms glossed. In places you will come across terms given in capital letters (e.g. DOWN'S SYNDROME in the gloss on page 5 for amniocentesis), indicating that they have their own entry elsewhere in Part 1.

Part 2 describes the most important legislation and official government reports that have affected special education over the last 130 years. We have had to select from a mass of material those Acts and reports most concerned with special education. However, legislation and reports in ordinary education and in health and social services also have a major impact on handicapped children. We have chosen some of the particularly important ones, but have had to leave out a great many more. In describing Acts and reports that are primarily concerned with fields other than special education, we have concentrated on the sections most relevant to special education—so the items of the glossary should not be read as comprehensive summaries.

Part 2 is arranged chronologically so that you can get an idea of what happened when, and the order in which things took place. To make it easy to find an Act or report, the index at the back refers to items by their most common name, e.g. *Plowden Report* rather than *Children and their Primary Schools*.

Part 1 Physical impairments and their related technical terms

albinism absence of skin pigment; a genetic disorder. Effects vary considerably, but typically there is almost no colour in the skin and eyes (which appear red because of visible blood capillaries). Long exposure to sun is more likely to cause skin cancer than in the case of people with pigment. People with albinism are sometimes partially sighted.

amniocentesis test for chromosomal and genetic abnormalities in a foetus (e.g. DOWN'S SYNDROME) carried out at 14–16 weeks of pregnancy—early enough for termination, so it functions as a screening device for prevention. The test involves sampling the amniotic fluid surrounding the foetus. The fluid is drawn off with a needle inserted into the womb (see Figure 1). Although many abnormalities can now be detected in this way, amniocentesis raises serious moral problems for parents and doctors.

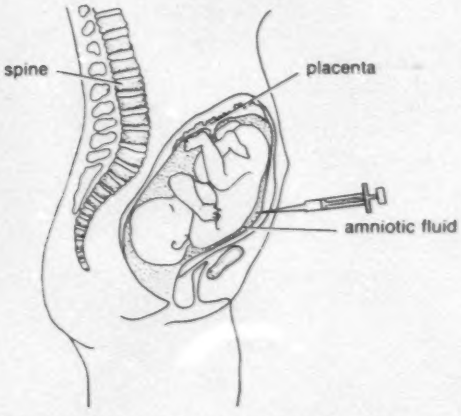


Figure 1 Amniocentesis needle entering the amniotic cavity.

anencephaly gross brain defect with malformation of the head; a fatal condition in which babies live two or three months at most. Part of the skull and part or all of the brain fail to develop. Seasonal and geographical variations suggest the action of a virus in pregnant women, or other factors such as diet. Alpha-foetoprotein from the liver leaks directly into the amniotic fluid and can be detected there. AMNIOCENTESIS has been used to detect anencephaly since 1972.

anoxia lack of oxygen—during pregnancy or, more usually, at birth; can lead to brain damage. It is sometimes caused by a rupture of the umbilical cord. However, the cause is not always obvious.

aphasia specific developmental language disorder. Children with receptive aphasia have normal hearing but cannot make sense of what they hear, and those with expressive aphasia cannot talk intelligibly. Aphasic children can be taught language with non-aural methods, and many achieve good spoken language as well.

asthma difficulty with breathing; wheezing and coughing, particularly at night. It can be caused by allergy to mites in dust, skin, bedclothes, etc., by infection, and by stress. There is usually a family history of asthma, ECZEMA and hay fever. Asthma involves bronchial spasms and obstruction by mucus, often after a cold. Asthma may affect up to three per cent of children.

autism condition about which there is considerable controversy. 'Early infantile autism' was first described by Leo Kanner, an American child psychiatrist, in 1944. He said these children 'show extreme aloneness from the beginning of life, and an anxiously obsessive desire for the presentation of sameness . . . The common denominator in all these patients is an inability to relate themselves in the ordinary way to people and situations from the beginning of life . . . The case histories indicate invariably the presence from the start of extreme autistic aloneness which, wherever possible, shuts out anything that comes to the child from the outside . . . They reject reality, tend to brood, and become obsessed with small repetitious activities' (quoted in Furneaux, 1981).

In 1961 a British working party described nine main diagnostic features:

(a) absence of emotional relationships;
(b) no self-identity; self-injury sometimes;
(c) pathological obsession with particular objects;
(d) resistance to changes in concrete environment or daily routine, possibly to maintain perceptual monotony;
(e) abnormal perceptual experience: avoiding visual/auditory stimuli, but showing insensitivity to pain or extremes of temperature;
(f) anxiety and irrational fears;
(g) lack of speech, misuse of personal pronouns and referring to self in third person;
(h) overactive or entranced state, rocking, spinning;
(j) serious intellectual retardation with 'islands' of normal, or exceptional, functioning.

While this adds up to a picture of severe, prolonged disorientation, children actually identified as autistic may have few characteristics in common. Developmental milestones are usually normal, except for the vital omission of language, in which they show no interest, comprehension or productive skills. Sometimes autistic children seem to suffer from hearing loss. Their appearance is normal, but their behaviour is unusual: no eye-contact, but mannerisms such as flapping, flicking, toe-walking; they may have an expressionless face, laugh inappropriately and have irrational fears. More boys than girls are autistic, although no-one seems to know why. Some children greatly improve during adolescence, but most retain serious language problems, ritualistic, compulsive behaviour, and an inability to make social relationships. Autism has been thought to be the result either of emotional deprivation in early infancy or of perceptual abnormalities that imply some brain damage.

blindness officially defined as sight worse than a certain level. Very few people are totally blind, without even a sense of light and dark. Children can suffer loss of sharpness (acuity) of vision that makes things blurred, restrictions to the size and shape of the visual field, and distortions of what they see. Acuity is measured using the familiar Snellen letter charts, and is expressed as a ratio such as 6/18 (i.e. that person can see at 6 metres what a person with normal vision can see at 18 metres).

Blindness is legally defined as 3/60 vision or worse, in the better eye. Partial sight is legally defined as being between 6/60 and 6/18 vision. Acuity however is a poor guide to functional sight in everyday settings, and educational definition does not rely on acuity measurements.

Visual impairment has many causes, for example retinoblastoma—where an hereditary malignant tumour grows on the eye. RUBELLA (German measles) in a newly pregnant woman can cause blindness in her child; other causes are meningitis, vitamin A deficiency, smallpox, RHEUMATOID ARTHRITIS (occasionally), untreated squint (strabismus), GLAUCOMA (an inherited high blood pressure in the eye), CEREBRAL PALSY (sometimes), and injuries. Partial sight is commonly caused by severe forms of common visual impairments such as short-sightedness (myopia) and astigmatism. Many visually handicapped children have other impairments as well.

brittle bones (fragilitas ossium) congenital fragility of bones, of varying severity. Babies can be born with fractured limbs, ribs.

cerebral palsy group of disorders of movement associated with damage to an area of the brain, affecting 2–2.5 per 1000 children. There are three main types: spasticity, athetosis and ataxia. **Spasticity**: can take many forms, all of which involve paralysis to the limbs. *Hemiplegia* involves spasticity on one side of the body, and is caused by damage to the motor area of one cerebral hemisphere (see Figure 2). Other types of

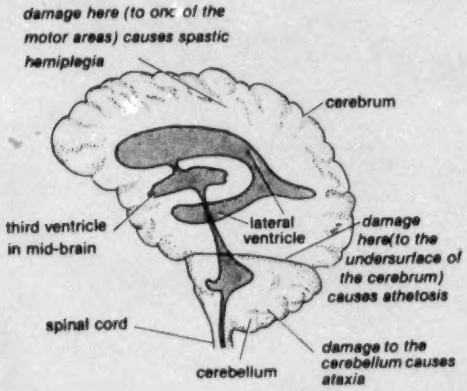

damage here (to one of the motor areas) causes spastic hemiplegia
cerebrum
third ventricle in mid-brain
lateral ventricle
damage here (to the undersurface of the cerebrum) causes athetosis
spinal cord
damage to the cerebellum causes ataxia
cerebellum

Figure 2 Side view of the brain, showing the position of the ventricles.

damage have different effects: in *diplegia* both sides of the body are affected; in *quadriplegia* all four limbs are weak or paralysed; in *paraplegia* there is spasticity only in the legs. **Athetosis**: caused by damage to the undersurface of the cerebrum (see Figure 2). People with athetosis have abnormal posture and slow involuntary writhing movements. **Ataxia**: caused by damage to the cerebellum (see Figure 2), resulting in uncoordinated movements and unsteadiness of gait. It is the most frequent kind of cerebral palsy found in ordinary schools.

Related disorders are hemiparesis (very mild paralysis on one side of the body) and dysarthria (a disorder of the production of speech).

Cerebral palsy can often be diagnosed at birth and is a permanent, non-progressive defect in an immature brain. However, the effects of cerebral palsy can in many cases worsen in the absence of treatment by physiotherapy.

Many cerebral palsied children suffer from a host of additional disabilities that can include: speech disorders (especially in athetosis), convulsions (especially in hemiplegia), poor concentration, mental retardation, DEAFNESS, visual impairment, visual–spatial problems, poor hand–eye co-ordination, poor laterality, poor teeth, incontinence, and dribbling. The range of characteristics and abilities of children with any one type of cerebral palsy is enormous.

chromosome (*chroma*, colour; *soma*, body) twisting, ladder-like threads of protein inside the nuclei of cells; the carriers of hereditary characteristics. We receive half our chromosomes from each parent and pass on half of ours to each child. Each cell has 46 chromosomes —22 pairs plus two sex chromosomes.

cleft palate opening along the centre of the palate in the roof of the mouth. A cleft palate is often associated with a hare (split) lip. Difficulties with speech are the main resulting problems.

club foot (talipes) congenital deformity of foot and ankle (can affect both feet). It is the result of the combination of a minor genetic abnormality, and environmental factors such as drugs or infections in the pregnant mother.

colour blindness The most common genetic condition is red/green colour blindness, which is seldom in fact a disability. Women are the carriers and about 8 per cent of white males are colour blind to some degree. (Total colour blindness is known as achromatopsia.)

congenital dislocation of the hip condition varying from a small abnormality in the pelvic socket for the hip bone, to a severe lesion. Malformation of the hip bone and laxity of the joints can have genetic causes. Poor intra-uterine posture can also cause dislocation. Dislocated hips are more common in girls than boys. Diseases that weaken the pelvic girdle raise the risk of dislocation, e.g. MUSCULAR DYSTROPHY, SPINA BIFIDA.

cretinism consequence of thyroid deficiency (hypothyroidism). Sufferers have varying degrees of general developmental delay and can have dry skin, coarse hair and a gruff voice, and are often dwarfed. If treated early with thyroxin, however, these children do not become mentally retarded.

cystic fibrosis genetic disease in which both parents are carriers but are themselves healthy. Cystic fibrosis is caused by the deficient secretion from the pancreas of enzymes necessary for digestion, and excessive secretion of thick mucus in the lungs. It occurs in about one in 2,500 births. Cystic fibrosis causes chronic lung infection and malabsorption of food, so sufferers take pills to help digest meals. The severity of the disease varies but death often occurs in late adolescence, from lung disease.

cytomegalovirus common virus, which can cause birth defects (e.g. of the eyes, heart, liver) and mental retardation if the mother is affected early in pregnancy. She has no symptoms except those of a very mild flu, so a person is not usually aware of having CMV. Some infants with CMV, however, can excrete the virus and so not be defective. CMV can be detected by blood tests but there is no satisfactory vaccine at the moment. It is possible, but rare, for a second child to be affected by CMV.

deafness hearing loss. It can take many forms, be due to many causes, and have varying consequences. Sounds vary in loudness and pitch, and people with hearing loss vary in their sensitivity to sounds of different loudness and pitch. It is usual to measure hearing loss by dividing it into loss of sensitivity at different pitches. Loss of sensitivity is measured in decibels (dB), and people may have little or no loss at some pitches, and large hearing loss at others. Figure 3 shows audiograms for four different children. These plot hearing loss in dB against pitch measured in Hertz (Hz). The audiograms are produced using a pure-tone audiometer, in which simple tones of varying pitches and loudness are presented to the person to detect. There is disagreement about the classification of degrees of hearing loss, but a rough guide is:

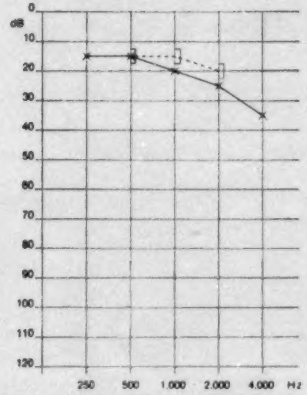
Mild	15–30 dB	Severe	65–95 dB
Moderate	30–65 dB	Profound	95+dB

Deafness may be produced by damage or disease to any part of the ear. The outer ear transmits air vibration to the eardrum. Blockage of wax here is a very common cause of temporary deafness. The middle ear transmits vibrations from the eardrum through a series of tiny bones to the inner ear, where vibrations are converted to nerve impulses. The middle ear can be damaged by infection, in particular otitis media, causing what is known as conductive deafness. Inner-ear damage is likely to be permanent and can result from infection or injury.

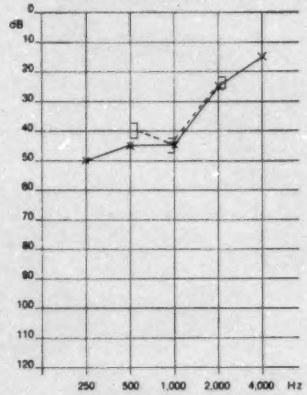
Some forms of deafness are genetic, some are caused by prenatal infection, for example by german measles, and many others result from infection or injury to the ear.

There is no straightforward relationship between hearing loss measured by an audiogram and functional hearing in everyday life. Children with similar audiograms can have markedly different language abilities

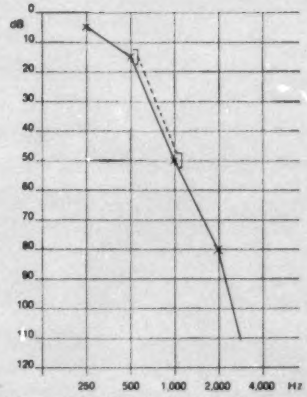
Figure 3 Pure tone audiograms for cases of perceptive (nerve) deafness.



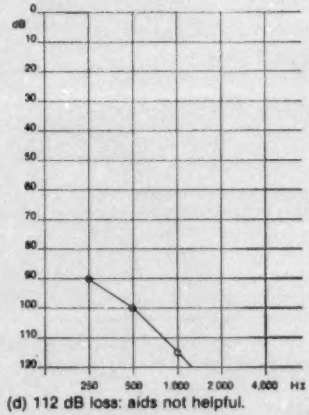
(a) 20 dB loss: no aid needed; speech normal.



(b) 38 dB loss: rare case of better hearing for high than for low frequencies; aids work well.



(c) can hear soft sounds of low frequency, but otherwise very deaf for most speech; aids not helpful — person needs to lip-read.



(d) 112 dB loss: aids not helpful.

Key ×] left ear ○ right ear —— air conduction - - - bone conduction

and educational attainments. Hearing aid technology has recently seen dramatic improvements, particularly in the development of radio aids that transmit from a teacher via an aerial to the child. These improvements have made a great difference to the education of hearing-impaired children.

diabetes deficiency in the pancreas, which causes a lack of the hormone, insulin, causing in turn an excess of glucose in the blood. Among the symptoms are: thirst, sugar in urine, acetone on the breath, high blood fats. Diabetics run the risk of later degenerative vascular disease, e.g. heart disease.

Down's Syndrome genetic condition that results from faulty cell division very early in the foetus's development and is nearly always non-hereditary. Children with Down's Syndrome are said to resemble each other, with oval-shaped heads, small eyes, large tongues, incurving little fingers, a single crease on their palms, and broad hands. They are usually on the short side. However, like any other children they also resemble their parents. The syndrome is usually associated with reduced intelligence, but the range of abilities is very wide and a number of people with Down's Syndrome are not mentally handicapped. One-quarter of people with Down's Syndrome suffer from congenital heart defects and about ten per cent develop cataracts. People with Down's Syndrome rarely have children, but their offspring would probably not inherit the syndrome. Down's Syndrome was first described by Dr John Langdon Down of the London Hospital in 1866. He coined the term 'mongolism', and his explanation involved tubercular parents and race degeneration.

dyslexia reading disorder (see Unit 11).

eczema common allergic rash beginning in infancy and persisting for several years. There is usually a family history of eczema, and some 40 per cent of sufferers later develop ASTHMA. There is a risk of impetigo if scratching causes infection. Eczema starts on the face and scalp and spreads to the inside of the elbow, knee and wrist joints. Corticosteroid ointment provides temporary relief but is too strong to use daily, and may make the condition worse.

encopresis no bowel control, faecal incontinence.

enuresis urinary incontinence. 'Primary' enuresis means that a child has never been 'dry'. 'Secondary' enuresis means that a child has been continent but is now incontinent.

epilepsy excessive electrical activity spreading from a 'focus' in the brain, causing attacks of varying degrees of severity. **Petit mal**: a mild form of epilepsy in which attacks of a few seconds involve staring, vacancy and a brief loss of consciousness, but no convulsion of the limbs and only rarely falling to the floor. Attacks can be frequent and occur in quick succession. They tend to occur particularly between the ages of four and eight and decline during adolescence. Petit mal does not cause brain damage. **Grand mal**: a more severe type of epilepsy, with many forms. The child suddenly becomes stiff, falls unconscious, twitches, turns blue, urinates and finally passes into deep sleep. There can be vomiting, headaches, weakness in a limb and severe abdominal pain. Grand mal attacks can last from a few seconds to several minutes, and prolonged grand mal can cause brain damage if not treated quickly. **Jacksonian epilepsy**: a form involving only one side of the body or one arm; it does not cause any loss of consciousness. It is associated with spastic hemiplegia (see CEREBRAL PALSY). **Temporal lobe epilepsy**: a form involving a build-up of bizarre behaviour ('aura') before attacks—chewing, smacking lips, overactivity, tantrums; this can go on for several hours with no loss of consciousness or convulsions. During the attack there could be inappropriate talking, laughing or sleep walking.

The causes of epilepsy are often unknown but can result from head injury, cerebral tumour, inflammation and CEREBRAL PALSY. Abnormalities of electrical activity in the brain can affect concentration and memory without causing convulsions, and changes in sensation and mood are often associated with epilepsy. Many epileptics suffer incontinence after an attack.

Drugs such as phenobarbitone are taken to control epilepsy, but can have undesirable side-effects. It is common for an epileptic to take several drugs at the same time.

foetoscopy technique for looking directly at a foetus through a tiny telescope-like instrument the width of a hypodermic needle. The foetoscope is inserted into the womb through the abdominal wall, under local anaesthetic, and can be used for the prenatal diagnosis of deformed or absent limbs, and spinal damage. Only a very small area of the foetus can be seen at once, however, and the foetus keeps moving about.

gene material in the nucleus of cells causing and regulating the development and production of bodily tissues. There are hundreds of genes on each CHROMOSOME in our cells. Genes are too small to be seen or photographed. Half our genes come from each parent. The position of each gene on a chromosome is fixed and matched with a gene on the other chromosome of the pair. The matched pair of genes together controls a hereditary function. Genes can therefore be 'mapped' on the chromosomes. Genes send chemical 'messages' to all parts of the body, controlling growth and bodily functioning.

glaucoma inherited high blood pressure in the eye, gradually causing BLINDNESS.

haemophilia genetic disease in which there is a deficiency in the blood of anti-haemophilic globulin (AHG)—a substance necessary for clotting. Only women can carry the disease, and only their sons are affected. The most serious effect is bleeding into the joints, which can cause paralysis. AHG can be made from donated plasma but the process is very expensive and requires a great deal of blood. The development of plasma injection has lead to much greater control of bleeding in haemophilia sufferers.

hydrocephalus 'water on the brain' causing enlargement of the head. An obstruction to the flow of cerebrospinal fluid (CSF) from the ventricles (four cavities in the brain, connected by narrow channels through which CSF passes) to the membranes round the brain and to the spinal cord. It is caused by congenital malformation, uterine infection or postnatal meningitis. The blocked fluid dilates the ventricles, swelling the head but compressing brain tissues. Four-fifths of children with SPINA BIFIDA have hydrocephalus. Hydrocephalus can be detected in the womb by ultrasound scan.

hypertrophy enlargement of an organ.

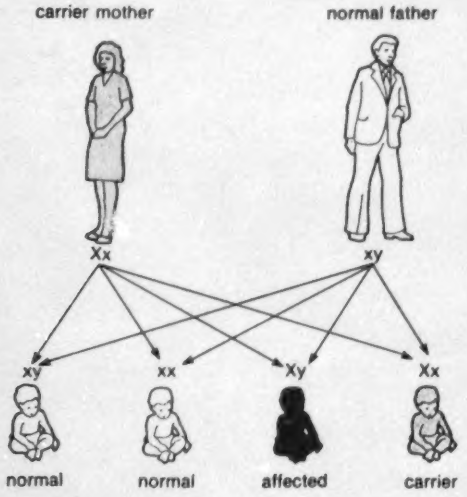
kyphoscoliosis (kyphosis, curvature of the spine; scoliosis, bending of spine to one side) condition associated with MUSCULAR DYSTROPHY and SPINA BIFIDA.

microcephaly condition in which the child has an exceptionally small head; it is usually associated with mental handicap. Microcephaly has many possible causes, but in many cases the cause is unknown.

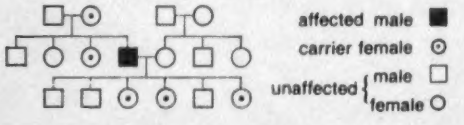
muscular dystrophy genetic, progressive muscular disorder. There are many types of muscular dystrophy; most common and most severe is Duchenne's (so-called in 1860s), which is a genetic disease affecting males only. There is progressive deterioration of the muscles for moving, swallowing and breathing, usually causing death during late adolescence. Females are carriers, half their male offspring are affected and half their female offspring are carriers. Affected boys seem normal at birth. Between 2–5 years of age their walking becomes clumsy, they lose their balance and fall a lot; running, climbing and standing become difficult. By the age of about 9–11, muscular dystrophy sufferers have to use a wheelchair. Their arms become weaker, and weakness in the back causes KYPHOSCOLIOSIS leading to poor sitting posture, for which braces can be worn. Breathing becomes difficult and chest infections are likely. Hip and shoulder muscles weaken—all voluntary muscles are eventually affected (except perhaps in the face) and this can extend to the heart, causing heart disease. Muscle is eventually replaced by fatty tissue.

There is no remission, only varying rates of development. Muscular dystrophy sufferers have an increased risk of DIABETES. There are several different theories about the cause of the disease. Muscular dystrophy is a sex-linked genetic disorder; see Figure 4.

Figure 4 Sex(X)-linked inheritance.



(a) The defective gene is carried on one X chromosome of the mother, who is usually healthy; disease follows when that X chromosome is transmitted to a male. For each male child, the odds of being affected are 50/50, and for each female child are 50/50 that she will be a carrier.



(b) A typical family tree of X-linked disease such as haemophilia or muscular dystrophy.

neurofibromatosis inherited genetic disorder affecting the brain and nervous system. There is a wide variation in the severity of the symptoms, from birthmarks like coffee stains, and soft, small lumps along the nerves, to large tumours developing on the nerves of any tissue or organ (brain, lung, kidney). Death may be early depending on site of tumours. There is a 50 per cent risk to the offspring of those affected.

orthopaedics the correction of physical deformities in children by means of surgery and aids.

Perthes's Disease hip disease in children in which the spongy head of the femur (thighbone) disintegrates. After some years, the condition does not progress further, but the hip needs support to prevent deformity.

phenylketonuria inherited biochemical disorder causing irreversible mental retardation if not treated. Sufferers have too much of the amino acid phenylalanine in their blood because of an enzyme deficiency. Phenylalanine is necessary for the making of all proteins, but this excess is toxic in PKU, so it has to be restricted and replaced by a synthetic protein. PKU children therefore have a carefully controlled diet which completely prevents adverse consequences.

poliomyelitis (*polios*, grey; *myelos*, marrow) inflammation of the grey matter of the spinal cord, sometimes called 'infantile paralysis', caused by a virus leading to fever, headache, vomiting, stiff neck and varying degrees of paralysis. It has virtually disappeared in the UK.

pyloric stenosis narrowing of the duodenum; a congenital HYPERTROPHY of the sphincter between the stomach and the small intestine, which causes a block. It is found in more boys than girls, and causes continual vomiting. Surgery slits the hypertrophic muscle fibres and leaves no disability.

rheumatoid arthritis (Still's Disease in children) chronic inflammation of the joints, which become painful, swollen and stiff. Deformities of the joints and weakness or shrinking of the muscles and tendons cause disability and pain when moving. About one-third of sufferers recover, one-third remain severely disabled, and one-third are mildly disabled. Some are liable to relapse. Children are frequently hospitalized for varying periods, and the disruption and pain can cause severe depression.

rickets defective bone growth due to lack of vitamin D. It is generally the result of poor diet or living in conditions where there is little sunlight. Vitamin D-resistant rickets is a much rarer genetic disease transmitted from affected males to all female offspring, who then require additional vitamin D and phosphates in their diet. Rickets affects growth and leaves sufferers with characteristic bow legs. It is very rare in the UK.

rubella (German measles) virus infection spread by droplets from the nose and throat. Glands at the back of the neck become swollen and tender and slight fever and sore throat follow. After 24 hours, a rash can develop on the face and after three days spreads over the body. There is no treatment and patients do not need to stay in bed. Rubella is moderately infectious. A second attack is very rare. Twenty-five per cent of children have the disease by the age of eight. If a mother has German measles in the first three months of pregnancy there is a risk of damage to the foetus. There is about a 25 per cent risk to the child of cataracts, heart disease, DEAFNESS, mental retardation, and hepatitis. The earlier the mother is infected, the worse the defects. (After the fourth month, there is no risk.) The eye, ear and heart are all developing at about the same time in early pregnancy, so all are liable to be affected.

spina bifida congenital malformation of the spinal cord, the covering of the cord and the nearby vertebrae. One-quarter of children so affected are stillborn or die soon after birth. There are two serious forms. **Meningocele:** a tumour or sac containing cerebrospinal fluid (CSF); the covering membranes are outside the spinal column. It does not affect the spinal cord and causes minimal disability. **Myelomeningocele:** a sac that contains both CSF and the imperfectly formed spinal cord. This damage to the nerves controlling the lower muscles, bowel and bladder results in varying degrees of paralysis to the lower body, and incontinence. There is obvious risk of injury, of the drying of the cerebrospinal fluid and of infection. About seventy-five per cent of spina bifida sufferers have HYDROCEPHALUS, caused by a malformation of the cerebellum. The neurological abnormalities can cause specific learning difficulties, e.g. brain stem damage impairs hand–eye co-ordination. Since the late 1950s spina bifida children have undergone surgery for orthopaedic corrections and for the insertion of the Spitz-Holter valve, which drains excess fluid from the ventricles of the brain into a silicone pump. From there it drains through a catheter into the veins and is reabsorbed into the body. Hydrocephalus is arrested by the valve. (See Figure 2 for the position of the ventricles in the brain.) Because of incontinence, spina bifida sufferers are liable to urinary tract disease, and to bone fractures because of decalcification, although damage to nerves means that there is no pain. Spina bifida sufferers also run the risk of dislocated hip, KYPHOSCOLIOSIS, and obesity. There is no necessary connection between spina bifida and mental retardation.

strabismus squint, eyes turning inwards.

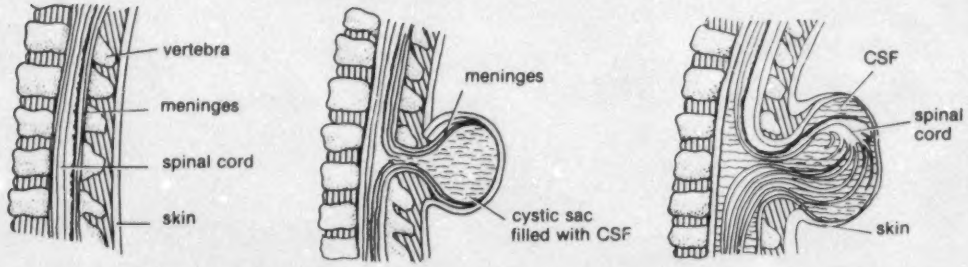


Figure 5 Section through normal spine, meningocele and myelomeningocele.

Reference

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Part 2 Legislation and official reports

1601 *Poor Law Act* This introduced secular responsibility for the poor, and enabled each parish to raise taxes for the aged, sick, orphaned, able-bodied unemployed and those impoverished by large families. Local Justices of the Peace appointed parish overseers who levied the poor rate, which was administered in the form of 'household' relief (pensions to those caring for dependants at home) or 'outdoor' relief (money or food, etc. given directly to the needy).

1834 *Poor Law Amendment Act* By the 1830s, the needs of the unemployed poor, and the need in an increasingly factory-based manufacturing economy for a mobile labour-force, dictated an overhauling of laws that were now 230 years old. So, in 1831, a Royal Commission was set up. The result was a new administrative framework and tougher conditions for receiving relief, but no attempt was made to support or redeploy those involuntarily out of work for long periods. A central Board of Commissioners, with locally elected Boards of Guardians, ended the independent control of relief by the parishes, which were grouped into 600 new Poor Law Unions. Applicants for relief had to be prepared to enter a workhouse, where life was made as punitive an experience as possible.

1861 *Report of the Commissioners Appointed to Inquire into the State of Popular Education in England (Newcastle Report)* This was the first survey of its kind, and the recently established Education Department (1856) briefed the commissioners in 1858 to discover what was necessary 'for the extension of sound and cheap elementary instruction to all classes of the people'. The main recommendations were that:

(a) there should be more state education (though not free or compulsory), but without any interference with the denominational bodies, and no centralized school management;

(b) partial funding should be by state capitation plus local rates;

(c) inspection of schools should be done by county and borough education boards;

(d) payments to schools should be made according to standards of work achieved.

Payment by results—(d)—was the only recommendation adopted by the government.

1862 *Poor Law Act* The Guardians were now empowered to pay for the maintenance and education of blind pauper children in special institutions, but many chose not to. The amount was not to exceed the cost of keeping the children in the workhouse, i.e. very little. However, the Guardians were hostile to the proposed repeal of these powers contained in the bill concerning the education of the blind and the deaf (Act passed 1893, see below), and the transfer of powers to the school authorities who would pay from the rates. (Also see *Report of the Royal Commission on the Blind, Deaf and Dumb and Others of the* UK, 1889, below.)

1866 *Industrial Schools Act* These forerunners of Approved Schools were designed to segregate from the community juvenile delinquents (i.e. poor, working-class children who got into trouble at school or on the streets), and came under the Home Office. ('Reform' schools had existed since the Reformatory Act of 1854.) After 1870, school boards initiated the establishment of residential industrial schools, which were punitive and retributive in attitude, and in which the regime usually consisted of some minimal educational work, training for a trade, PE and corporal punishment.

1867 *Metropolitan Poor Act* The Poor Law Board (from 1871, the Local Government Board) was empowered to combine into one district the Poor Law Unions and parishes of London to establish asylums for pauper imbeciles. The Metropolitan Asylums Board was set up with representatives of each union and parish, and was not dissolved until 1929 when the Local Government Act handed over all the institutions in the control of the Metropolitan Asylums Board to the LCC.

1870 *Elementary Education Act* W. E. Forster, a Quaker and vice-president of the Education Department in Gladstone's first administration from 1868, intended to fill the gaps in areas short of voluntary schools—with state elementary schools administered by the ne school boards. These boards were to be directly elected local bodies, independent both of the voluntary societies and the Education Department. The 'Cowper–Temple' clause forbade any denominational religious teaching; voluntary schools could claim up to a 50 per cent grant from the Education Department, but there were to be no more building grants; school boards could raise an education rate; school fees were retained and compulsory attendance between the ages of five and thirteen remained a local option; HMIs would carry out school inspections on behalf of the department and parents could choose which school to send their children to. So, in 1870, state education was to be neither universal nor free—nor compulsory.

1876 *Elementary Education Act* (*Lord Sandon's Act*) The controversy about compulsory attendance in elementary schools was partly resolved by this Act, by which school boards could set up school attendance committees, and by which it became the duty of parents to see that their children went to school.

1880 *Elementary Education Act* Largely the work of A. J. Mundella, vice-president of the Education Department, this Act was designed to strengthen the 1876 Act (see above). School attendance committees were to introduce by-laws to enforce attendance up to the age of 13; they were to follow the pattern already adopted in London where each local division of the school districts had its own attendance committee, with a superintendent and a team of visitors, approximately one for every 3,000 children. At this date, most truants who were not disabled or ill were out doing paid work.

1886 *Idiots Act* This was mainly concerned to distinguish between 'idiots' and 'lunatics', because the former could be deprived of property rights permanently, whereas the latter could only be deprived during their periods of insanity. There were few voluntary asylums for idiots, but this Act did not empower local or central public bodies to establish more. The Metropolitan Poor Act 1867 (see above) was an exception. Idiot asylums built later were registered under the 1886 Act, and people could then by compulsorily detained in them up to the age of 21.

1888 *Local Government Act* This reorganized local administrative boundaries to create county and borough councils. Its relevance to education is that it provided a national, uniform, administrative structure which could become the basis for LEAs, especially for the expanding field of secondary education. Moves to establish this in the 1890s failed, but the 1902 Education Act (see below) finally established the county and borough councils (with the exception of London) as the new LEAs, thus replacing elected school boards by permanent professionals.

1889 *Prevention of Cruelty to Children Act* This made it possible to remove children from their parents if there was a risk of their coming to harm. It was used as a precedent when recommendations were made for residential special schools for the defective and epileptic (see *Report of the Departmental Committee of the Education Department on Defective and Epileptic Children*, 1898).

1889 *Report of the Royal Commission on the Blind, Deaf and Dumb and Others of the* UK (*Egerton Report*) The commissioners were briefed to study the provision for children excluded from the Elementary Education Acts. The 'others' referred to in the report's title were mentally retarded children who were unable to keep up with the required school standards.

For blind children, the commissioners' recommendations were that:

(a) there should be compulsory education from five to sixteen, provided directly by the school authorities or paid for if in other institutions;

(b) the aim of such education should be employment, as with sighted children, and the avoidance of dependence upon the state;

(c) education should be alongside sighted peers where possible, with the support of peripatetic specialist teachers or centres for special classes.

For 'deaf and dumb' children the commissioners did not insist either upon oral or manual sign methods, but said that all children should, as far as possible, be taught to speak and lip-read. They recommended that:

(a) grants be paid automatically to special classes for the deaf, without inspection or general examination;

(b) school boards pay for children who went to any other institution certified by the Education Department;

(c) all children be taught separately from normal children, usually in residential schools;

(d) school be compulsory from seven to sixteen (they believed that no language teaching was possible for the deaf before the age of seven);

(e) boys and girls be educated separately to prevent their marriage and the perpetuation of congenital deafness;

(f) teachers of the deaf be better paid than those of hearing children;

(g) teacher-training be better financed than that of teachers of hearing children;

(h) teacher-training colleges be subsidized and supervised by the government, and that students be already qualified teachers.

Here was a mixture of what, to us, appear to be progressive and reactionary opinions.

The report made an attempt to define 'idiot' and 'imbecile' in terms of differences in degree, not kind. Imbeciles were 'educable'—but only in special classes devoted to sense training, PE, and speech and perception, rather than to the three Rs. They should not remain either in workhouses or lunatic asylums, and could be educated up to the age of 21 and taught by trained teachers. 'Feeble-minded' children (roughly corresponding to present-day categories of 'remedial' and 'ESN(M)') were not specifically excluded from the Education Acts, and so this report of 1889 did not say much about them, except that their education should be segregated.

1893 *Elementary Education* (*Blind and Deaf Children*) *Act* When it was finally passed in 1893, this Act placed upon school authorities a duty to educate blind children (from five to sixteen) and deaf children (from seven to sixteen), but it made no statement on the location of provision; HMIs would inspect the provisions, and certify satisfactory schools which would receive a meagre parliamentary grant. Few new schools opened, as many school authorities were too small to need or provide one, so most new pupils went to residential institutions, and many in small towns and rural areas were not catered for. (See also 1921 Education Act; 1937 Education (Deaf Children) Act.)

1896 *Report of the Departmental Committee of the Local Government Board on the Poor Law Schools* This advocated separate provision for feeble-minded children in Poor Law schools, and was one reason why the Committee on Defective and Epileptic Children was set up at the end of that year.

1898 *Report of the Departmental Committee of the Education Department on Defective and Epileptic Children* The Education Department had done nothing to implement the recommendations of the 1889 Egerton Report—that special education should be provided for mentally defective children. 'Feeble-minded' children were now to be known as 'mentally defective', 'who cannot properly be taught in ordinary elementary schools by ordinary methods'. They were to be distinguished from 'imbeciles', who were unable 'to receive proper benefit from instruction in the special classes'. Selection for special school was recommended to be undertaken by a doctor appointed by the school authority. All school boards should provide for all defective children in their area. Compulsory attendance should be from seven to fourteen, and to sixteen optionally. Physically defective children who were not mentally retarded should be assisted by guides or transport to the ordinary schools, since school authorities were not able to provide tuition at home or in hospital. Epileptic children could attend ordinary or special schools and teachers should be taught how to help with their attacks.

1899 *Elementary Education* (*Defective and Epileptic Children*) *Act* Largely on account of the expense that the implementation of the 1898 report (see above) would entail, this Act merely *permitted*, rather than compelled, school authorities to provide education for the mentally and physically defective, and for epileptic children. By 1902, only 87 authorities

had adopted the Act and, by 1909, only 133 out of 328 new LEAs had done so. However, it does represent the first official involvement of school authorities with educable defective children, defined as: 'who not being imbecile and not merely dull and backward, are by reason of mental or physical defect incapable of receiving proper benefit from instruction in ordinary schools' (see 1908 *Report of the Royal Commission on the Care and Control of the Feeble-Minded*).

1902 *Education Act* School boards and attendance committees were abolished, and responsibility for education was transferred from the school boards to the counties, county boroughs and urban district councils. School boards had not been officially empowered to provide secondary education, which now became the province of the LEAs. Voluntary schools came under the new LEAs, so compulsory attendance was now applicable to them.

1904 *Report of the Interdepartmental Committee on Physical Deterioration* The Lord President of the Council, the Duke of Devonshire, appointed the committee in 1902 as a result of accumulating evidence of the poor physical condition both of children in elementary schools and of the men who presented themselves as volunteers to fight in the Boer War. This report made over 50 recommendations, three of which concerned school-children: that there should be special schools for delicate children, who would spend a short time there; that the school authorities should have a duty to inspect all children medically; and that the authorities should provide school meals.

1906 *Education (Provision of Meals) Act* This was the result of the 1904 report on physical deterioration. It was a Private Member's Bill that gave LEAs the power to provide meals by means of a ½*d.* rate.

1907 *Education (Administrative Provisions) Act* By this Act, LEAs were compelled to provide medical inspection for school-children, and so the School Medical Service was established. Also in 1907, the Board of Education established a Medical Branch—directed by Dr George Newman (who held the job until 1935)—which also inspected special schools. Newman was in favour of LEA clinics for medical treatment, as well as inspection.

1908 *Report of the Royal Commission on the Care and Control of the Feeble-Minded* (*Radnor Report*) The Royal Commission was appointed as a result of eugenic and financial problems: what was to be done about a growing population of supposedly hereditary mental defectives, who were considered a sign of racial degeneration and were an expensive burden on the taxpayers? Mary Dendy and Ellen Pinsent (see Unit 9) gave evidence that special schools were of little value to those who really needed lifelong residential care. The commission accepted these views, recommending permanent segregation for the feeble-minded. The report therefore advocated the exclusion of mentally defective children from the terms of the 1899 Elementary Education Act (see above) and their transfer to local mental deficiency committees, with special schools passing from the Board of Education to the Board of Control.

1913 *Mental Deficiency Act* Those who gave evidence to the Radnor Commission went on to actively campaign for legislation, but this 1913 Act bore little resemblance to the 1908 recommendations. The Royal Commission had defined the feeble-minded in social terms as 'persons who . . . are incapable . . . of competing on equal terms with their normal fellows; or of managing themselves and their affairs with ordinary prudence'. The Act placed more emphasis on educational criteria: 'in the case of children . . . they by reason of such defectiveness, appear to be permanently incapable of receiving proper benefit from the instruction in the ordinary schools'. The Act distinguished between idiots, imbeciles, the feeble-minded and moral imbeciles. The education of the feeble-minded was to remain with the LEAs, who also now had a specific duty to ascertain which children aged between seven and sixteen were mentally deficient. Only those incapable of being educated even in special schools should be certified and become the responsibility of mental deficiency committees. However, feeble-minded children should be compulsorily segregated in special schools. Thus the LEAs, the mental deficiency committees, and the Poor Law Guardians, were all involved in the care of these children.

1914 *Elementary Education (Defective and Epileptic Children) Act* The 1913 Act favoured the idea that the feeble-minded should be educated in schools. But it did not specify the LEA's duties towards the 'educable' mentally deficient, beyond that of ascertainment. This Act made it compulsory for LEAs to set up special schools for the feeble-minded.

1918 *Education Act* This was the result of dissatisfaction with the education system, aroused by the First World War: people were equally placed to be killed on the battle-field, but unequally placed to receive education. The Act raised the school leaving age to 14. It abolished the half-time exemption system whereby those aged 11–13 divided their time between school and job, and it required those who left at 14 or 15 to carry on part-time school for eight hours a week until they were 18. The 1918 Act contained a clause significant for special education—the 1899 Act (see above) was no longer to be permissive with regard to the education of physically handicapped children (see 1921 Education Act).

1921 *Education Act* Disabled children were excluded from the general provisions of this Act, but Sections 51–69 brought together the provisions of (see above) the 1893 Act for the blind and deaf, the 1899 and 1914 Acts for the defective and epileptic, and the 1918 Act for the physically handicapped. According to Section 80, LEAs were now permitted to provide medical treatment as well as to inspect schools; boarding arrangements with voluntary schools could be made for difficult children ('maladjusted' was not yet an official category and LEAs could not therefore provide their own residential schools). Special education was to take place in special schools or certified special classes—not in ordinary schools.

1926 *Report of the Consultative Committee on the Education of the Adolescent* (*Hadow Report*) This report advocated a change of school at 11 years, when 'children are beginning a fresh phase in their education, which is different from the primary or preparatory phase, with methods, standards, objectives and traditions of its own'. These views were heavily influenced by Cyril Burt, who was the major contributor to the first Hadow Report (1924) on psychological testing in schools. Hadow now recommended that the school leaving age be raised to 15, and that there be 'primary' and 'secondary' schools—these latter organized on the tripartite system (also derived from Burt) of grammar, technical and modern.

1929 *Report of the Joint Departmental Committee on Mental Deficiency* (*Wood Report*) George Newman, Medical Officer to the Board of Education, appointed this committee originally to investigate the incidence of feeble-mindedness (LEA returns varied wildly and were no basis for an administrative reform) and to outline an education system for such children. The brief was not specific, however, and the committee extended it to cover all mentally deficient children. Cyril Burt, Dame Evelyn Fox, Dr A. F. Tredgold and Dame Ellen Pinsent were members of the committee. Dr E. O. Lewis carried out a large-scale survey and discovered that only about half the children identified as mentally deficient had places in special schools, and that there were probably many thousands not yet identified.

Despite the eugenic and segregationist views of some of the members of the committee, the Wood Report contained a number of progressive recommendations: that certification be abolished, that LEAs run occupation centres for the 'ineducable', and that the mental deficiency committees compel attendance at these centres between the ages of five and fifteen. Adhering to the ideas of the emerging psychometrics, the committee recommended that children with an IQ of 50 or less become the responsibility of the mental deficiency committees, and that those with IQs of 50–70 be grouped with those of IQ 71–80 (the 'dull and backward') and together be known as the 'retarded' children, to be educated in ordinary schools with special help. Just as the 1913 and 1914 Acts (see above) had not been implemented on any significant scale, so the impact of the Wood Report was not felt until 1944. Provision for the mentally deficient marked time while the committee sat (1924–9), and after the report the economic depression intervened.

1931 *Report of the Consultative Committee on the Primary School* (*Hadow Report*) Susan Isaacs's *Intellectual Growth in Young Children* appeared in 1930, and her ideas on the way that young children should be educated were reflected in the third Hadow Report, which argued that activities and experience should take precedence over the cramming of facts

in primary schools, that these schools should be coeducational, that pupils should not be streamed until the age of ten, and that classes should not exceed 40. This report confirmed the break at 11, and also divided the primary school into infants (five to seven) and juniors (eight to eleven).

1934 *Report of the Committee of Inquiry into Problems Relating to Partially Sighted Children* The first special class for children with partial sight opened in 1908 in Camberwell, but many children elsewhere were still being educated as if they were blind. The committee recommended that partially sighted children be taught alongside sighted children, in special classes in ordinary schools, where they could join up for oral work; that they do more reading and, despite the safety risks, more PE; and that some of the existing residential special schools for the blind be reorganized for the partially sighted.

1937 *Education (Deaf Children) Act* This, at long last, reduced the compulsory school age from seven to five. However, the Act was not implemented until after 1945.

1938 *Report of the Committee of Inquiry into Problems Relating to Children with Defective Hearing* The first special class for the partially deaf had opened in Bristol in 1908, and the LCC opened one soon after that. The children learnt lip-reading, and had extra writing, spelling and speech training, but otherwise their curriculum was that of the ordinary school. Partially hearing children had not previously been treated as a separate category.

The report divided the partially hearing into three groups: those who could cope in an ordinary school with special help, those who would also need an aid and a peripatetic teacher of lip-reading, and those who would need a special school because of serious language difficulties. The first residential special schools for the category were opened subsequently, and in 1945 partial hearing became an official category of handicap.

1938 *Report of the Committee on Secondary Education (Spens Report)* This confirmed and crystallized the work of Burt and the recommendations of the Hadow Reports (see above, 1926 and 1931). There should be transfer at 11+, tripartite secondary education (either by streaming or, preferably, in separate schools), and selection should be by mental tests: 'It is possible at a very early age to predict with some degree of accuracy the ultimate level of a child's intellectual powers'. The Spens Report rejected comprehensive (or 'multilateral') schools as being too large, because the academic side would dominate, and 'the general adoption of the multilateral idea would be too subversive a change to be made in a long-established system'. The committee recommended raising the school leaving age to 16, appointing careers masters, and having no physical or social distinction between the intake for grammar and modern schools.

1943 *Educational Reconstruction* (*White Paper*) Here appeared the first doubts about the 11+ and segregated secondary education, with arguments that the junior school is often just a crammer for the 11+ exam, and that the different parts of the secondary system are far too isolated from each other, with grammar schools enjoying a disproportionate prestige. Selection for secondary education, argued this White Paper, should be according to school records, not competitive tests, the school leaving age should be 15, and parents should be more involved. School meals, milk and medical inspection were still important. The government's aims were:

> to secure for children a happier childhood and a better start in life; to ensure a fuller measure of education and opportunity for young people and to provide means for all of developing the various talents with which they are endowed and so enriching the inheritance of the country whose citizens they are. The new educational opportunities must not, therefore, be of a single pattern. It is just as important to achieve diversity as it is to ensure equality of educational opportunity.

1943 *Report of the Committee of the Secondary Schools Examinations Council on Curriculum and Examinations in Secondary Schools (Norwood Report)* This report contained long descriptions of the three psychological stereotypes (more or less undiluted Burt) into which pupils conveniently distribute themselves, thus justifying tripartite segregation at secondary level. Like the Spens Report, the Norwood Report showed a great concern for administrative practicality. Each of the three main groups of children would have a different curriculum.

1944 *Education Act* Lobbied for and planned over four years from 1940 by R. A. Butler, appointed Wartime President of the Board of Education by Churchill, this Act has since then formed the basis of the education system in England and Wales. Butler saw it as the means to rid the country of the waste of economic potential engendered by unequal educational opportunities available to 'the two nations'. He also used it to resolve the increasingly touchy problem of inadequate church-run voluntary schools.

The Act established, for the first time, free secondary education for all, and established in law the Spens recommendation that transfer to secondary education should be at 11+. LEAs were given the duty to secure 'sufficient (primary and secondary) schools to provide full-time education for junior and senior pupils'. 'Sufficient' was defined as 'sufficient in number, character, and equipment to afford for all pupils opportunities for education offering such variety of instruction and training as may be desirable in view of their different ages, abilities and aptitudes . . .' LEAs were also obliged to provide for under-fives in nursery or infant schools, and for further education and training of young people after school. It was the Minister of Education's job

> to promote the education of the people of England and Wales and the progressive development of institutions devoted to that purpose, and to secure the effective execution by local authorities, under his control and direction, of the national policy for providing a varied and comprehensive educational service in every area.

('Comprehensive' meant no more than 'all-embracing'.) Just how much control and direction the minister could use was never spelt out; clarifying this ambiguity has been at the root of policy-making since 1944.

The Act said nothing about the form secondary education should take. Butler accepted the tripartite system (see 1938, Spens Report) and believed that the new secondary modern schools would be 'of equal standing' in the quality of teaching and amount of resources they would have. He argued that the demise of all-age elementary schools which provided for most working-class children would also be the demise of inequality of opportunity.

The Act established in Sections 33 and 34 the legal basis of special education. These sections are quoted in full and thoroughly described in Unit 8. Section 57 confirmed the exclusion from education of severely mentally handicapped children who could, after medical examination, be deemed ineducable and referred to the local mental deficiency committee, under the aegis of the Board of Control.

1946 *Report of the Care of Children Committee* (*Curtis Report*) Partly as a result of the need to find places for over 5000 children made homeless during the Second World War, it came to public attention that the care of children living away from home left much to be desired. The committee found administrative confusion and a large number of children living in unpleasant and inadequate places. The committee also paid attention to provision for handicapped children. It was disturbed to find a number of severely handicapped children in ordinary residential settings, and although it discovered much wrong with specialist provision, it was careful to emphasize its lack of expertise.

In its recommendations it drew a sharp dividing line between provision for ordinary children and provision for handicapped children. For the former, matters were revolutionized; for the latter, little changed, and to support the boundary it established, it wanted handicapped children removed to specialist institutions. Normal children were to be separated from adults in care, 'defective' children were (as a consequence of the segregation it recommended) placed alongside adults. Quality of care for many normal children was to improve dramatically, but the committee made no recommendations on the care of 'defective' children to the relevant bodies. The only positive recommendation was a call for more specialist institutions.

The proposals for normal children led to the 1948 Children's Act under which local authorities set up children's committees with a children's officer as chief executive. Children's homes were placed under this new administration. This pattern of care was to last for over 20 years.

1955 *Report of the Committee on Maladjusted Children* (*Underwood Report*) This was the first full-scale review of provision for maladjusted children since the category was first established in 1945. The committee was to review 'the medical, educational and social problems relating to maladjusted children, with reference to their treatment within the educational system'. The report established the philosophy on which attitudes and provision have developed up to the present day. Heavily influenced by psychoanalytic thinking, the report viewed maladjustment as an individual problem caused primarily by genetic predisposition and early family life. Schools were given little place as *causes* of the problem. It saw the principal agency of treatment as the child guidance clinic, to be staffed by psychiatrists, educational psychologists and psychiatric social workers. The effect of this was to place control firmly in medical hands, even going so far as to propose that referral to special educational provision should only take place on the recommendation of a child guidance clinic. It called for more special school provision, particularly in day schools, in which the teacher's 'prime function' would be 'not to teach but to help each child to release the emotional tension which prevents him from learning'. Under the category of prevention, the report mentioned health visitors and mental health education, but it did not mention the contribution ordinary schools might make.

1959 *Handicapped Pupils and Special School Regulations* These established the categories of handicapped pupils in force up to 1981. These are listed in Appendix 1 of Unit 1/2.

1959 *Mental Health Act* Many of the recommendations of the Royal Commission on Mental Illness and Mental Deficiency, which sat during 1954–7, were implemented in this Act. Under it, the Board of Control was abolished, and residential provision for the mentally ill and mentally handicapped was absorbed into the NHS. Local health authorities were given powers to provide community care, in the form of training centres, hostels and homes. The Royal Commission considered whether education authorities should be responsible for severely mentally handicapped children, but decided against a transfer, opting instead to recommend compulsory attendance at training centres and the substitution of the words 'unsuitable for education in school' for 'ineducable'. The Act implemented these recommendations. Mental health services are governed today by it.

1963 *Half Our Future: report of the Central Advisory Council* (*England*) (*Newsom Report*) This was devoted to the education of pupils between the ages of 13 and 18 of 'average and less than average ability', i.e. the bulk of children in what were then secondary modern schools. Its recommendations were designed to correct the inequalities of provision it found between grammar and secondary modern schools. For example, it found 40 per cent of secondary modern schools suffered from inadequate buildings and, in slum areas, the figure was 79 per cent. The report pressed for the raising of the school leaving age (ROSLA) to 16, the development of appropriate curricula and examinations, a building programme to replace inadequate provision, and changes in teacher-training aimed at training for 'Newsom' pupils. However, the report gave little or no attention to the selective system itself, despite growing evidence that selection at 11+ and segregation into two types of school were themselves major causes of the concerns that lead the committee to be established. Rather than organizational change, the report saw salvation in a change of attitudes.

1965 *Circular 10/65* Post-war Labour governments had been content to follow a non-partisan line of support for the tripartite system, but when a Labour government was returned in 1964 attitudes and policies had changed. Anthony Crosland issued Circular 10/65, which called on local authorities to submit plans for full comprehensive reorganization. The circular had no statutory force, and many doubted its chances as an instrument of policy since there were no sanctions proposed against recalcitrant LEAs, and a very wide range of possible options for LEAs to adopt. By 1967, in fact, 159 out of 194 LEAs had submitted schemes. In 1965 only 8.6 per cent of the school population were in comprehensives, but by 1975 the figure had risen to 68 per cent, and by 1980 it stood at 86 per cent.

1967 *Children and their Primary Schools: report of the Central Advisory Council* (*England*) (*Plowden Report*) In many ways this represents the peak of optimism about the power of education as a means to social change. The committee began work in 1963 with the task of considering primary education in all its aspects, and the transition to secondary education. Its background was the ineffective implementation of the 1931 Hadow Report (see above), and the focus on secondary schooling of the 1944 Education Act (see above).

The report has made a major contribution to the theory and practice of the process of primary education (and its role in society), although its philosophy has been severely criticized by a number of educationalists. It analysed the existing state of affairs in depth, and produced many recommendations on which it placed carefully ordered priorities. First, it called for the establishment of educational priority areas (EPAs)—areas of marked social deprivation into which would pour a major injection of resources as a means of positive discrimination of educational opportunities towards deprived children. EPAs were assumed to contain ten per cent of the child population. Second, teacher aides should be appointed; third, the considerable number of old and inadequate buildings should be replaced; fourth, nursery education should be extended, starting in EPAs, and eventually available for all four-year-olds. Fifth, ages of transfer between stages should change: first school from five to eight, middle school from eight or nine to twelve, secondary school from 12 or 13 onwards. Other recommendations included: closer links between home and school should be encouraged; teachers should be ready to teach English to immigrant children. The report devoted a chapter to handicapped children in ordinary schools. It made a limited number of recommendations on their treatment, including the idea that they should be identified as early as possible and, most significant, that there should be a full-scale inquiry into the education of handicapped children.

Plowden has had a profound effect on the development of primary education, although it has often been inaccurately blamed as the root of progressivism and lowered standards of attainment—the report is much more conservative than most people realize. It also made a major contribution to the ending of selection at 11+. The government implemented the EPA proposals very quickly, and injected large sums for buildings and extra allowances for teachers. In 1972 the government announced an expansion of nursery provision on the scale Plowden envisaged, although this never took place. A number of LEAs switched to middle schools. Teacher aides, however, were never introduced. A number of later reports had their origin in Plowden recommendations: the James Committee on teacher training, the Warnock Committee (see below), and the Taylor Committee on school government (see below).

1968 *Report of the Committee on Local Authority and Allied Personal Social Services* (*Seebohm Report*) Local social services developed in a fragmented manner after the Second World War so that within each local authority there existed a children's department, a welfare department for the old and disabled, some housing departments doing social welfare work, and a number of services (such as training centres) for the severely subnormal. This produced administrative confusion, and inadequate, inefficient services. It was Seebohm's job to solve this problem. The principal recommendation was that all local social services should be merged into comprehensive social services departments providing a unified family-based service with broader responsibilities. Many detailed recommendations were also made about individual services. The government accepted the general principles, and introduced social services departments under the Local Authority Social Services Act 1970. However, the report received mixed reviews: a number of people argued that it failed to establish the level of need in the community, and that as a result it never prescribed precisely what a family social service would look like. As a result the solution was largely administrative. Many handicapped children and adults have not fared well, since services for them are easily swamped in large departments which encourage generic social work and discourage specialization.

1970 *Chronically Sick and Disabled Persons Act* Introduced as a Private Member's Bill by Alfred Morris, this Act gives local authorities the duties to discover which people in their own area are disabled, and to provide them where necessary with domestic help and nursing, adequate housing, holidays and recreation and, where home care is impossible, with residential care. The Act also made it a duty for LEAs in building new schools and colleges to provide means of access and suitable toilet and parking facilities for disabled children and adults 'in so far as it is in the circumstances both practicable and reasonable'. The Act also gave LEAs the duty to inform the Secretary of State of provision they made for deaf-blind, autistic and 'acute dyslexic' children, and to educate them in schools in the LEA. The provisions of the Act have never been fully implemented, and some people have maintained that services have declined in some areas. This is principally due to lack of central government financial backing. The DES drew LEAs' attention to their new duties in a circular, but the regulations governing school buildings have never been amended accordingly.

1970 ***Education (Handicapped Children) Act*** After much lobbying, and recommendations in official reports during the 1960s, this Act transferred the responsibility for mentally handicapped children from local health departments to LEAs. A sizeable building programme followed to replace inadequate facilities and develop new schools where needed, and a programme was developed to convert teaching staff to qualified teacher status.

1971 ***Better Services for the Mentally Handicapped (White Paper)*** This document still provides the official guidelines on which mental handicap services are based. It was produced in the wake of the most sustained critical public attention to the conditions in mental subnormality hospitals that there has been in post-war years. A number of inquiries at hospitals such as Ely and Farleigh revealed not only individual shortcomings, but a failure of the whole service for mentally handicapped people. The White Paper's principles centred on community care and support for families, in terms that were very similar to the Mental Health Act 1959 (see above). It set targets for provision in residential and day care facilities, and envisaged a substantial reduction in the number of people in large hospitals. However, it continued to maintain that hospitals were the right places for a small number of very severely handicapped children. Paradoxically, the White Paper set no targets for the development of domiciliary services, and envisaged a growth in the numbers of mentally handicapped people in residential care.

1972 ***Children with Specific Learning Difficulties: report of the Advisory Committee on Handicapped Children (Tizard Report)*** The term 'dyslexia' established its place in educational language with reference to two types of reading problem: that caused by injury to the brain of a competent reader, and retardation preventing a child ever becoming a competent reader. It was the debate about the second of these, and whether such a specific condition existed, that was made the focus of this inquiry. The outcomes of the committee's debate were, firstly, a scepticism about the existence of a syndrome of 'dyslexia'. Preferring the term 'specific reading difficulties', the report saw these problems as one part of the wider issue of reading backwardness in general. It recommended regular screening and monitoring of progress, the development of skilled remedial teaching in all schools, and the development of remedial education centres. The report added to a general movement to improve remedial teaching, but it is difficult to identify any definite impact that it had on practice. (See Unit 11.)

1972 ***Raising of the School Leaving Age (ROSLA) Order*** Under a provision of the 1944 Education Act (see above), and after continued recommendation dating back to the Crowther Report in 1959, the school leaving age was finally raised to 16. The order was fully implemented by 1974, by which time cynicism had developed that the government's primary motive was to keep unemployment down—not to enhance educational opportunity.

1972 ***Report of the Committee on the Education of the Visually Handicapped (Vernon Report)*** The committee conducted a thorough survey of the education of blind and partially sighted children in the UK, and compared practices with other countries. Among its recommendations were:

(a) all visually handicapped children under five should receive some form of education, which might be by peripatetic teaching;

(b) screening for visual handicap should be part of the normal school health service;

(c) teacher-training should be improved for ordinary and specialist teachers;

(d) there should be a national plan for the education of the visually handicapped that would ensure even distribution of provision.

On the subject of integration, the report proposed experimentation, but envisaged little change in the number of special school places needed. It was criticized by some of the voluntary bodies representing blind people for not having advocated integration as a principle. Although many of the report's recommendations were accepted by the government of the time, the Warnock Report in 1978 (see below) noted only 'slow progress'.

1972 ***Report of the Committee on Speech Therapy Services (Quirk Report)*** A potential crisis in speech therapy services motivated this report. There were far too few therapists—nearly all women—working in poor conditions in a hitherto undervalued service that was beginning to be recognized as having an important role. The report represents the professionalization of a previously underrated short-term occupation. It recommended that: speech therapists be involved at all stages in the treatment of language-disordered people;

services be organized under Area Health Authorities with a clear career structure; the number of therapists be increased; initial training be at degree level, and be followed by supervised practice.

1974 *Report of the Committee on One-Parent Families* (*Finer Report*) By the mid-1960s it had become clear that the welfare state was not going to eradicate poverty. And, as many people benefited from rising living standards, the contrast with those who did not became increasingly apparent. Among the most disadvantaged and deprived groups were one-parent families, and in the face of considerable political pressure and increasing numbers of single parents bringing up children alone, Richard Crossman appointed a committee of inquiry under Sir Morris Finer in 1969. The report came out in 1974 and dealt comprehensively with issues of family law, social security, day care for pre-school children, housing, and employment. Key recommendations covered: a new cash allowance payable as a right to all one-parent families; a single and uniform system of family law; protection of housing following marital breakdown; flexible employment policies; better employment opportunities for women; a considerable increase in day-care provision and better support, from schools, for single parents. In a time of economic crisis and political uncertainty, the government's reception was cool. The special allowance was rejected, but there were some improvements in supplementary benefits, and the new child benefit scheme helped. Day-care and nursery provision have increased, but largely by more part-time places whereas full-time places are needed. The employment position, for women and men, has steadily worsened.

1975 *A Language for Life* (*Bullock Report*) Partly under the stimulus of the Black Papers, the early 1970s saw a protracted and largely party-political row about standards of literacy and numeracy in schools. Much of this was fuelled by misconceptions about how much 'progressive teaching' was going on. The row hit a peak following a small study by the National Foundation for Educational Research, which suggested that reading standards had not improved in ten years. Less than a month later, Margaret Thatcher, then Secretary of State for Education, set up the Bullock Committee to examine reading and the use of English in schools. In all, the committee made 332 recommendations but no evidence was found that standards had fallen. Most recommendations were to do with teachers—how they were trained and what they did in school. Various changes and improvements were proposed for children with reading difficulties, and these echoed many of those in the Tizard Report three years earlier (see above).

The committee wanted early screening, inter-professional collaboration, diagnostic tests, better-resourced remedial departments supporting children in ordinary lessons, and each LEA to have a specialist advisor. The by-then Labour government's response was minimal, if not non-existent, and no extra resources were made available, although a survey in 1976 by *The Times Educational Supplement* found that one-quarter of LEAs were trying to implement Bullock policies, two-thirds had a specialist English advisor, and one-half had a formal screening system. The financial cuts of the late 1970s and early 1980s have hit remedial provision hardest of all, and the government was harshly criticized in 1980 by its own inspectorate for this position.

1975 *Circular 2/75 The Discovery of Children Requiring Special Education and the Assessment of their Needs* This circular was the DES's response to the considerable confusion surrounding the 'ascertainment' of children in need of special education. The procedures in use, involving the forms HP1—HP5, were cumbersome. But, more important, they put medical officers in the key position in the process. Many LEAs interpreted the procedures as requiring a medical officer to examine a child and give advice before placement occurred. Furthermore, many LEAs were using formal certification procedures in all cases, when these were only in fact necessary when the LEA wished to coerce parents to send their child to a special school. The circular replaced the HP forms with the new forms SE1—SE6 (see the Reader, Reading 4.3, for more detail). Being a circular, the recommendations were only advisory. The effect of this 'SE' procedure, now adopted by most LEAs, has been to further reduce the role of the medical officer in the process of referral, and to enhance the status of the educational psychologist who now has a form designed specifically for his or her use.

The circular warmly commended multi-professional assessment, but proposed that either an educational psychologist or an advisor for special education should 'convey a recommendation about the nature of special education required and where it should be provided' to the LEA. In practice it is usually one of these people who takes the decision. Because of the framing of Section 34 of the 1944 Act, the SE procedure still contains a 'certificate form', needed if compulsion is envisaged, and this can still only be completed by a medical officer. (See Unit 8.)

1976 *Education Act* This was intended to complete the process of comprehensive reorganization begun in 1965 by Circular 10/65 (see above). By 1975 only Kingston-upon-Thames had no comprehensive schools at all, but 60 LEAs had not submitted full plans for reorganization, and seven rebel LEAs refused to do so. The effect of the Act, instituted by Reg Prentice and introduced by Fred Mulley, was to lay down in law for the first time the form secondary provision should take—'in schools where the arrangements for the admission of pupils are not based (wholly or partly) on selection by reference to ability or aptitude'. It also allowed the Secretary of State to require LEAs to submit plans for re-organization and to force their implementation, although it transpired in the case of Tameside LEA that the legal means to coerce were weaker than the government believed. The bill originally excluded any reference or application to children categorized as in need of special educational treatment. However, a House of Lords amendment brought about Section 10, which amended Section 33(2) of the 1944 Act. This change meant that except where it 'is impracticable or incompatible with the provision of efficient instruction', or would involve 'unreasonable public expenditure', special education was to be provided in ordinary schools. However, the section was never implemented and was superseded by the 1981 Education Act.

1976 *Fit for the Future: report of the Committee on Child Health Services* (*Court Report*) The need for this inquiry was rather different from what finally stimulated its establishment. Despite the burgeoning of the NHS and undoubted improvements in child health, Britain still had an infant mortality rate greater than most Western countries, and the health chances of children varied enormously between regions and social classes. This state of affairs showed the need for an inquiry, but what stimulated it was the reorganization of the NHS in 1973. This left several professional groups, especially the ex-school medical officers, confused as to their role, and without a career structure. The committee was appointed in 1973 by Sir Keith Joseph, then Secretary of State for Health and Social Security, under the chairmanship of Professor Donald Court.

The sizeable report covered all aspects of child health, but at the root of its philosophy was the recommendation that there should be one integrated child health service, rather than the existing service fragmented between the school health service, GPs and hospitals. The new integrated service was to operate at two levels: a primary health care team based in local areas, offering preventive and therapeutic services and linked to a district service offering more specialized care and treatment in district general hospitals.

For handicapped children, Court proposed the setting up of specialist District Handicap Teams based on district general hospitals. These were to be multi-professional teams providing specialist advice, support and treatment to which parents would have direct access. For children with 'psychiatric disorders', the report recommended an integration of child guidance clinics with hospital-based child psychiatry clinics.

The report was met by the inertia and opposition of much of the medical profession combined with a delayed and limited government response, not backed by financial commitment. Although the government committed itself to the 'overall philosophy of the Court Report', it has not had the means to implement an integrated service. Some District Handicap Teams have been established, but the way they work varies enormously, since the government gave no guidance. (See also Reading 4.4 in the Reader, and Section 2 of Unit 7.)

1977 *A New Partnership for our Schools: report of the Committee of Inquiry into the Management and Government of Schools* (*Taylor Report*) Before this report, the basis for the operation of governing bodies of schools was Sections 17–22 of the 1944 Act. By the mid-1970s there was considerable dissatisfaction with a system dominated by LEA political appointees who formed governing bodies that were often rubber stamps for

headteachers' actions. The Taylor Report proposed a major shift in the composition of governing bodies, and a great increase in their powers. It recommended that governing bodies consist of equal numbers of LEA appointees, members of the local community, parents, and teachers. The new bodies were to involve themselves in all aspects of the day-to-day running of the school, including the curriculum, organization, finance, staff appointments and admissions policies. The effect of these recommendations would be to interpose a new authority between head and LEA, with power to control the individual school's policies.

The report met strong opposition from teacher unions ('a busy bodies' charter', said the NUT), from educational administrators and from many LEAs that did not relish such a loss of power. The government's response was to separate the issue of composition of governing bodies from the issue of how much power they should have. The Labour government produced a bill which fell because of the 1979 election, but its provisions on school governors were largely incorporated in the new Conservative government's Education Act 1980, introduced by Mark Carlisle. This Act (see also below) for the first time says that parents and teachers should be represented by law on governing bodies, but it does not alter the majority representation of LEAs, and is remote from Taylor's 'four equal shares'. Taylor's terms of reference specifically excluded special schools, but the Warnock Report (1978, see below) endorsed the report's principles as equally applicable, and the 1980 Education Act's provisions on governors apply to special schools as well as ordinary schools.

1977 *Truancy and Indiscipline in Schools in Scotland: report of a Committee of Inquiry (Pack Report)* Concern in the early 1970s about the apparent increase in discipline problems, truancy and disruptive behaviour in Scottish schools—linked to worry about a growing juvenile crime rate—prompted this inquiry which began in July 1974. There is no parallel report for England and Wales. The committee's job was to investigate the problems of truancy and indiscipline in both primary and secondary schools, and to propose ways of reducing them. It was also to pay particular attention to the circumstances in which suspension from school could be justified.

Its recommendations were a mixture of recognition of flaws in the education system, and acceptance of that state of affairs. It supported the establishment of 'day units' for seriously disruptive children, but at the same time put forward many recommendations to make the curriculum and organization of schools more suited to the needs of less able or more difficult pupils. In all, there were 141 recommendations, touching on issues such as guidance and counselling, punishment, management, social work support, teacher-training, curriculum, and parent–school links.

1978 *Special Educational Needs: report of the Committee of Inquiry into the Education of Handicapped Children and Young People (Warnock Report)* This has been one of the most important influences on special educational policy and practice in the late 1970s and early 1980s, and is the document to which nearly all LEAs refer when they wish to guide, support and justify their actions and plans. Set up in November 1973 by Margaret Thatcher, then Secretary of State for Education and Science, it was chaired by Mary Warnock, ex-headteacher of a girls' grammar school, philosophy don, and fellow of St Hugh's College, Oxford. The committee began its work in September 1974 and reported in May 1978. This was the first comprehensive examination of special education in England, Wales and Scotland (*not* Northern Ireland) this century.

The key to understanding the report is the statement made by Mary Warnock on many occasions subsequently—that it contained nothing dramatically new: it was a summary and distillation of what the committee considered to be existing good practice. Gradualism was the philosophy underlying the policy proposals.

The report argued that the scope of special education should be widened, and services should be based on the assumption that one in five children at some time during their school career will require some form of special educational provision. In line with this, statutory categories were to be abolished but, in order to protect the interests of children with severe disabilities, some children (it was not spelt out who) should be 'recorded' as in need of special education. These children should have their needs assessed and reviewed regularly by a multi-professional team, and a record of their needs maintained centrally. Discovery, referral and assessment should take place in a systematic way,

involving five stages of assessment. At each stage progressively more professional expertise would be brought in; different children would need to be assessed up to different levels. Parents should be clearly involved in assessment. Records of a child's progress should be maintained by schools and made available to parents; however, 'the results of professional consultations and sensitive information' should be confidential and not available to parents.

The report put great emphasis on the early identification and education of children, which should start as young as possible. Once a disability was identified, parents should be told of available services. One person should be designated as the 'named person' who would be a point of contact for parents. This could be a health visitor or social worker in the early days, a headteacher during the school years, then a careers officer. Nursery provision should be greatly expanded, and a comprehensive peripatetic teaching service should be provided. In the early years, parents should be seen as the main educators of their child.

By redefining special education to include 20 per cent of children, it then followed that most special education would take place in ordinary schools. However, the Warnock Committee's approach was not to state a clear policy that all handicapped children should be in ordinary schools. As Mary Warnock said later: 'People have said we fudged the issue of integration, but we fudged it as a matter of policy' (*The Times Educational Supplement*, 25 May 1978). The report foresaw the development of a range of provision, with a continuing role for special schools to provide for children with severe or complex disabilities, and for children with severe emotional or behavioural disorders. It also envisaged that special schools would be centres of advice and expertise, and resource centres servicing other schools in an area. Where children with special needs were integrated, the committee's concern was to ensure that a plan for meeting their needs was made, that there would be a designated specialist teacher in the school, and that resource centres would be established to support handicapped children. The Secretary of State should issue guidelines before Section 10 of the 1976 Education Act was implemented.

The needs of school-leavers and over-16s were also a high priority. Pupils' special needs should be assessed—with their future in mind—at least two years before the pupils were due to leave. Every special school should have careers guidance, and every secondary school should have access to a specialist careers teacher. Pupils should be able to stay at school after 16 (in fact this was the law under the 1944 Act anyway). A major expansion of further education opportunities should occur, and employment policies should be changed to allow more handicapped people to work.

The report called for a major expansion of teacher-training, at both initial and in-service levels. There should be a special education element in *all* initial training courses, and the great majority of teachers serving in ordinary schools should take a short in-service course on special needs. There should be a recognized qualification for teachers with responsibility for teaching children with special needs.

Other recommendations called for: an expanded Advisory and Support Service in each LEA; more educational psychologists; better co-ordination between health, education and social services and between professionals; a continuing role for voluntary organizations; and a Special Education Research Group to co-ordinate and promote research.

The report was, in general, well received by LEAs and professional bodies. The government's response was to consult over 300 organizations about all aspects of the report. The consultation period ended in the spring of 1979: most organizations supported the recommendations, although a small number argued that the issue of integration had been avoided. In fact Mary Warnock spoke on a number of occasions warning that integration was taking place too hastily, and that a more continuous approach was needed—a view that ignored evidence that integration was not in fact occurring for any groups except those with sensory handicaps. Hers was the overwhelming view of professional bodies. Mary Warnock's own priorities were for more in-service teacher-training, and more co-operation between services. The outgoing Labour government in 1979 had not yet acted on the report. In March 1980, the new Secretary of State for Education, Mark Carlisle, stated that the government accepted Warnock's 'philosophy', and proceeded to introduce early legislation. The White Paper, *Special Needs in Education*, was published in August 1980; the Special Education Bill 1981 followed. This provides for substantial changes in the legal basis of special education. In repeated statements, ministers said that the changes 'would not give rise to significant additional expenditure'.

1979 *Education Act* This was one of the first Acts passed under the new Conservative government. It repealed Sections 1–3 of the 1976 Education Act (see above), thus removing LEAs' duty to submit plans for comprehensive reorganization. It also enabled LEAS whose plans for reorganization had already been approved, to revoke them.

1979 *Report of the Committee of Inquiry into Mental Handicap Nursing and Care* (*Jay Report*) In the wake of the continual disquiet—and occasional outcries—about the conditions in mental subnormality hospitals, the Jay Committee was set up to investigate the kind of care mentally handicapped people need, and how it should be provided. The model of care it proposed was based on three principles:

(a) Mentally handicapped people have a right to enjoy normal patterns of life within the community.

(b) Mentally handicapped people have a right to be treated as individuals.

(c) Mentally handicapped people will require additional help from the communities in which they live and from professional services if they are to develop to their maximum potential as individuals.

The most important consequence of these principles was that eventually there should be no more subnormality hospitals. Calling its recommendations 'unashamedly idealistic', it said that all mentally handicapped people should live in the community, preferably with their own families, or alternatively in small homes (of from four to six people) set in ordinary housing. The recommendations on staff-training provoked most reaction. The committee argued for an end to mental subnormality nurse training, and for a new Certificate in Social Service that should be a qualification in residential care work. Staff who wanted to work with children would take a further specialist course qualifying them as specialist child-care workers. These recommendations were to bring the care of mentally handicapped children into the general child-care system for the first time. The staffing and training proposals produced vehement opposition from the medical establishment, the nursing profession and the unions, and the government rejected the proposal for a new training pattern. However, the report had a major impact on government policy statements about the remaining 3500 children in subnormality hospitals: a clear policy statement came in the 1981 Green Paper on mental handicap community care, that no more children would be admitted, and those already in hospitals would be moved out to community-based homes.

1980 *Education Act* This brought about important changes in the law concerning the government of schools, parental choice of school, and school closures. Its origins are a mixture of some recommendations from the Taylor Report (see above), Conservative policy on parental choice, and ideas on easing the process of the closure and merging of schools under threat from falling numbers.

Under the Act, all schools—including special schools—are required to have parent and teacher governors, although in most cases these will continue to be a minority of the governing body, with the majority being LEA appointees. The Act made no changes, however, in the powers and duties of governors. For the first time, parents have a right to express a preference for the school they wish their child to attend, and the LEA must comply unless this would prejudice efficient education or the efficient use of resources. However, because of other provisions in the Act that allow an LEA to state the maximum class size for a school, it is not clear whether parental choice will actually increase. These provisions on parental choice do not apply to nursery schools or special schools. The Act revokes a requirement of the 1944 Act that LEAs submit plans for all schools in their area to the Secretary of State, and LEAs no longer require approval from the Secretary of State for all school closures. This is now only required where there is public opposition to the closure of a maintained school or of any voluntary school. Provision for under-fives is now discretionary, following confusion about exactly what the 1944 Act required. Thus LEAs do not now have a duty to provide for under-fives. The Act is also the legal basis for the 'assisted places scheme', whereby the government gives financial help to parents who want to send their children to private schools.

1980 *Inequalities in Health: report of a DHSS Working Group (Black Report)* In 1977 David Ennals, then Labour Secretary of State for Health and Social Security, commissioned this report to study the problems of inequalities between the social classes in health and health services, and to make policy proposals. It revealed a disturbing picture of inequality, which showed that the health of the lower social classes had improved little in 30 years. Working-class people, it showed, die sooner and are less healthy than middle-class people; they use medical services less frequently, get poorer services, eat poorer food, smoke more and take less exercise. Some of the disparities are now greater than 30 years ago. Working-class children are more vulnerable to disease and accident; infant mortality rates are much higher for working-class infants; boys aged between five and nine are twice as likely to die if they come from working-class than from middle-class homes. The report attributed these inequalities to inequality of income, to lack of adequate services in health, social security and education, and to poor working conditions, nutrition and housing. It recommended: a substantial shift of resources towards areas of particular deprivation; larger child and maternity benefits; free school meals for all; creation of an infant-care allowance; adequate day care for under-fives; and improvements in working conditions. All these came within the scope of 'national health goals'. The report's findings and recommendations were so alarming and unacceptable to the government that publication was withheld and the matter hushed up. A small number of photocopies of the original report had already been circulated.

1981 *West Indian Children in our Schools: interim report of the Committee of Inquiry into the Education of Children from Ethnic Minority Groups (Rampton Report)* Continuing concern and political pressure about the underachievement of West Indian children in school led to the establishment of this committee shortly before the 1979 general election. Its job was to review the educational needs and attainments of children from ethnic minority groups, to consider ways of keeping these under review, and to make recommendations on the issue. The interim report caused disquiet in government and education circles, particularly among teachers' unions, for it argued that a major determinant of West Indian underachievement was the racism of teachers. It said that only a small minority of teachers was openly racist, but a major problem was 'unintentional racism'—negative attitudes and low expectations, which lead to different and poorer educational treatment. However, the report also identified poor pre-school care, difficult social conditions, and parental attitudes as contributing to West Indian underachievement. By comparison, Asian children did as well or better than white children.

The report made extensive recommendations, which it argued were largely without financial implications. They were aimed at creating a multi-cultural education in which the life-styles of ethnic minority children are valued, and racial bias is eliminated. Shortly before the publication of the interim report, the committee's chairman, Sir Anthony Rampton, was dismissed by Mark Carlisle, Secretary of State for Education and Science, amidst criticism of his handling of the committee. Commentators, however, suspected that the government found the report's conclusions unacceptable. Rampton was replaced by Lord Swann, who will chair the committee up to the final report.

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